Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VA Central Arkansas Veterans HCS - 598

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Estimated Number of Veterans who are Chronically Homeless: 400

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1000 (estimated number of homeless veterans in service area) **x chronically homeless rate (40 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	276	0
Transitional Housing Beds	201	0
Permanent Housing Beds	261	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	We will continue using HUD Section 8 vouchers through the VASH program and will continue participation in the Jericho Coalition and the Joseph Project through the HUD Continuum of Care.
Help finding a job or getting employment	We will continue use of VA job counselors and will continue working with the Disabled Veterans Outreach Program through the Workforce Investment Board for the Department of Labor. We will also continue looking at options and opportunities for expanding
Dental care	We plan to continue working with River City Ministry and the Open Hands (Health Care for the Homeless) clinic.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **31** **Non-VA staff Participants: 60.0%**
Homeless/Formerly Homeless: **3.2%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.66	4.0%	3.47
Food	4.00	.0%	3.80
Clothing	3.79	.0%	3.61
Emergency (immediate) shelter	3.54	15.0%	3.33
Halfway house or transitional living facility	3.54	11.0%	3.07
Long-term, permanent housing	3.17	41.0%	2.49
Detoxification from substances	3.86	.0%	3.41
Treatment for substance abuse	3.90	7.0%	3.55
Services for emotional or psychiatric problems	3.8	7.0%	3.46
Treatment for dual diagnosis	3.6	7.0%	3.30
Family counseling	3.31	.0%	2.99
Medical services	3.83	11.0%	3.78
Women's health care	3.57	4.0%	3.23
Help with medication	3.55	.0%	3.46
Drop-in center or day program	4.17	7.0%	2.98
AIDS/HIV testing/counseling	3.86	4.0%	3.51
TB testing	4.07	.0%	3.71
TB treatment	4.04	.0%	3.57
Hepatitis C testing	4.04	.0%	3.63
Dental care	2.48	26.0%	2.59
Eye care	2.83	11.0%	2.88
Glasses	3.00	4.0%	2.88
VA disability/pension	3.64	.0%	3.40
Welfare payments	3.18	.0%	3.03
SSI/SSD process	3.38	.0%	3.10
Guardianship (financial)	2.89	7.0%	2.85
Help managing money	2.82	4.0%	2.87
Job training	3.11	19.0%	3.02
Help with finding a job or getting employment	3.44	37.0%	3.14
Help getting needed documents or identification	3.21	4.0%	3.28
Help with transportation	2.82	11.0%	3.02
Education	3.11	4.0%	3.00
Child care	2.68	22.0%	2.45
Legal assistance	2.61	11.0%	2.71
Discharge upgrade	3.37	.0%	3.00
Spiritual	3.68	.0%	3.36
Re-entry services for incarcerated veterans	3.07	7.0%	2.72
Elder Healthcare	3.14	11.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.13
Co-location of Services - Services from the VA and your agency provided in one location.	1.67
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.53
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.64
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.73
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.07
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.07
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.67
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.93
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.94
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.71

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CHALENG 2005 Survey: VA Gulf Coast HCS - 520, Biloxi, MS, Pensacola, FL

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 86

2. Estimated Number of Veterans who are Chronically Homeless: 22

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 86 (estimated number of homeless veterans in service area) **x chronically homeless rate (26 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds		
Transitional Housing Beds		
Permanent Housing Beds		

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: .

3. CHALENG Point of Contact Action Plan for FY 2005

	(no plan submitted this year)
	(no plan submitted this year)
	(no plan submitted this year)

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **Non-VA staff Participants: .0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene		%	3.47
Food		%	3.80
Clothing		%	3.61
Emergency (immediate) shelter		%	3.33
Halfway house or transitional living facility		%	3.07
Long-term, permanent housing		%	2.49
Detoxification from substances		%	3.41
Treatment for substance abuse		%	3.55
Services for emotional or psychiatric problems		%	3.46
Treatment for dual diagnosis		%	3.30
Family counseling		%	2.99
Medical services		%	3.78
Women's health care		%	3.23
Help with medication		%	3.46
Drop-in center or day program		%	2.98
AIDS/HIV testing/counseling		%	3.51
TB testing		%	3.71
TB treatment		%	3.57
Hepatitis C testing		%	3.63
Dental care		%	2.59
Eye care		%	2.88
Glasses		%	2.88
VA disability/pension		%	3.40
Welfare payments		%	3.03
SSI/SSD process		%	3.10
Guardianship (financial)		%	2.85
Help managing money		%	2.87
Job training		%	3.02
Help with finding a job or getting employment		%	3.14
Help getting needed documents or identification		%	3.28
Help with transportation		%	3.02
Education		%	3.00
Child care		%	2.45
Legal assistance		%	2.71
Discharge upgrade		%	3.00
Spiritual		%	3.36
Re-entry services for incarcerated veterans		%	2.72
Elder Healthcare		%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	
Co-location of Services - Services from the VA and your agency provided in one location.	
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	

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CHALENG 2005 Survey: VAMC Alexandria, LA - 502

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 8000

2. Estimated Number of Veterans who are Chronically Homeless: 3360

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 8000 (estimated number of homeless veterans in service area) **x chronically homeless rate (42 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	693	100
Transitional Housing Beds	327	50
Permanent Housing Beds	913	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Will encourage faith-based and non-profits to submit for VA Per Diem grants.
Long-term, permanent housing	Will engage informal relationships/partnerships with local housing assistance programs.
Childcare	Will support opening of day drop-in center where child care is provided.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **73** **Non-VA staff Participants: 79.1%**
Homeless/Formerly Homeless: **35.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.75	6.0%	3.47
Food	3.89	15.0%	3.80
Clothing	3.71	9.0%	3.61
Emergency (immediate) shelter	3.74	12.0%	3.33
Halfway house or transitional living facility	3.56	23.0%	3.07
Long-term, permanent housing	3.37	38.0%	2.49
Detoxification from substances	4.16	2.0%	3.41
Treatment for substance abuse	4.26	9.0%	3.55
Services for emotional or psychiatric problems	3.9	17.0%	3.46
Treatment for dual diagnosis	3.7	9.0%	3.30
Family counseling	3.32	2.0%	2.99
Medical services	4.11	6.0%	3.78
Women's health care	3.40	.0%	3.23
Help with medication	3.98	2.0%	3.46
Drop-in center or day program	3.38	4.0%	2.98
AIDS/HIV testing/counseling	3.74	4.0%	3.51
TB testing	3.69	.0%	3.71
TB treatment	3.51	.0%	3.57
Hepatitis C testing	3.84	6.0%	3.63
Dental care	3.03	28.0%	2.59
Eye care	3.34	15.0%	2.88
Glasses	3.33	4.0%	2.88
VA disability/pension	3.36	24.0%	3.40
Welfare payments	2.98	.0%	3.03
SSI/SSD process	3.02	2.0%	3.10
Guardianship (financial)	3.18	2.0%	2.85
Help managing money	3.09	.0%	2.87
Job training	3.12	23.0%	3.02
Help with finding a job or getting employment	3.37	4.0%	3.14
Help getting needed documents or identification	3.64	4.0%	3.28
Help with transportation	3.69	11.0%	3.02
Education	3.28	10.0%	3.00
Child care	2.78	4.0%	2.45
Legal assistance	2.84	6.0%	2.71
Discharge upgrade	3.21	.0%	3.00
Spiritual	3.78	6.0%	3.36
Re-entry services for incarcerated veterans	3.06	6.0%	2.72
Elder Healthcare	3.51	4.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.09
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.09
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.93
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.14
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.58
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.76
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.14
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.89
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.21
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.32

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.96
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.93

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CHALENG 2005 Survey: VAMC Fayetteville, AR - 564

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 350

2. Estimated Number of Veterans who are Chronically Homeless: 91

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 350 (estimated number of homeless veterans in service area) **x chronically homeless rate (26 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	210	0
Transitional Housing Beds	49	30
Permanent Housing Beds	72	40

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Continue to work with HOUSE, Inc. on implementing the VA Grant and Per Diem Program. It was approved for 33 beds and a van.
Long-term, permanent housing	Will continue to work with HOUSE, Inc. on receiving funding from the Dept. of Agriculture for building single room occupancy apartments. This to transition veterans from GPD to long-term housing.
Job training	Quality of Life Associates in Fayetteville Arkansas is looking for funding to provide job training for veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **18** **Non-VA staff Participants: 94.4%**
Homeless/Formerly Homeless: **5.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.06	6.0%	3.47
Food	3.61	24.0%	3.80
Clothing	3.56	12.0%	3.61
Emergency (immediate) shelter	3.11	28.0%	3.33
Halfway house or transitional living facility	2.56	44.0%	3.07
Long-term, permanent housing	2.00	47.0%	2.49
Detoxification from substances	3.33	12.0%	3.41
Treatment for substance abuse	3.33	12.0%	3.55
Services for emotional or psychiatric problems	3.2	12.0%	3.46
Treatment for dual diagnosis	3.2	.0%	3.30
Family counseling	2.67	6.0%	2.99
Medical services	3.76	.0%	3.78
Women's health care	3.22	.0%	3.23
Help with medication	3.00	.0%	3.46
Drop-in center or day program	3.17	6.0%	2.98
AIDS/HIV testing/counseling	3.06	.0%	3.51
TB testing	3.39	.0%	3.71
TB treatment	3.44	.0%	3.57
Hepatitis C testing	3.06	.0%	3.63
Dental care	2.39	12.0%	2.59
Eye care	2.94	.0%	2.88
Glasses	2.83	.0%	2.88
VA disability/pension	3.50	6.0%	3.40
Welfare payments	3.00	.0%	3.03
SSI/SSD process	2.72	.0%	3.10
Guardianship (financial)	2.44	.0%	2.85
Help managing money	2.33	.0%	2.87
Job training	2.67	24.0%	3.02
Help with finding a job or getting employment	2.83	12.0%	3.14
Help getting needed documents or identification	2.67	6.0%	3.28
Help with transportation	2.61	12.0%	3.02
Education	2.56	12.0%	3.00
Child care	2.11	12.0%	2.45
Legal assistance	2.06	6.0%	2.71
Discharge upgrade	3.06	.0%	3.00
Spiritual	3.28	.0%	3.36
Re-entry services for incarcerated veterans	2.56	.0%	2.72
Elder Healthcare	3.06	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.18
Co-location of Services - Services from the VA and your agency provided in one location.	1.47
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.53
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.71
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.24
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.12
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.50
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.63
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.59
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.12
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.38
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.25

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.82
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.63

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Houston, TX - 580

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 3500

2. Estimated Number of Veterans who are Chronically Homeless: 770

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 3500 (estimated number of homeless veterans in service area) **x chronically homeless rate (22 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	800	1500
Transitional Housing Beds	400	250
Permanent Housing Beds	500	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 30

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Establish a 40-bed domiciliary.
Long-term, permanent housing	Expansion of beds at midtown Terrace opening of 200 bed SRO through new housing.
Elder Healthcare	Will attend monthly meetings of Restorative Justice Community which is a faith-based coalition that seeks to bring the judicial/prison system together with service providers for ex-offenders.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **15** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **26.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.60	7.0%	3.47
Food	3.73	21.0%	3.80
Clothing	3.53	.0%	3.61
Emergency (immediate) shelter	2.73	21.0%	3.33
Halfway house or transitional living facility	2.87	29.0%	3.07
Long-term, permanent housing	2.60	43.0%	2.49
Detoxification from substances	3.07	.0%	3.41
Treatment for substance abuse	3.15	21.0%	3.55
Services for emotional or psychiatric problems	3.1	21.0%	3.46
Treatment for dual diagnosis	3.0	14.0%	3.30
Family counseling	3.31	7.0%	2.99
Medical services	3.87	.0%	3.78
Women's health care	3.31	7.0%	3.23
Help with medication	3.67	.0%	3.46
Drop-in center or day program	3.77	.0%	2.98
AIDS/HIV testing/counseling	3.73	.0%	3.51
TB testing	3.93	.0%	3.71
TB treatment	3.73	.0%	3.57
Hepatitis C testing	3.67	.0%	3.63
Dental care	3.27	21.0%	2.59
Eye care	3.47	7.0%	2.88
Glasses	3.33	.0%	2.88
VA disability/pension	3.53	7.0%	3.40
Welfare payments	3.20	.0%	3.03
SSI/SSD process	3.00	7.0%	3.10
Guardianship (financial)	2.93	.0%	2.85
Help managing money	2.67	.0%	2.87
Job training	3.60	14.0%	3.02
Help with finding a job or getting employment	3.47	14.0%	3.14
Help getting needed documents or identification	3.53	.0%	3.28
Help with transportation	3.33	.0%	3.02
Education	3.21	7.0%	3.00
Child care	3.00	.0%	2.45
Legal assistance	2.69	7.0%	2.71
Discharge upgrade	2.93	.0%	3.00
Spiritual	3.46	.0%	3.36
Re-entry services for incarcerated veterans	2.53	21.0%	2.72
Elder Healthcare	3.00	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.92
Co-location of Services - Services from the VA and your agency provided in one location.	2.08
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.08
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.62
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.85
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.92
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.85
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.69
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.23
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.69
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.31

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.79
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.71

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Jackson, MS - 586

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1050

2. Estimated Number of Veterans who are Chronically Homeless: 315

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1050 (estimated number of homeless veterans in service area) **x chronically homeless rate (30 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1741	50
Transitional Housing Beds	882	50
Permanent Housing Beds	125	75

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Supporting: (1) HUD application for permanent housing in Jackson, Ms. Area (2) a women's project (Mountain of Faith Ministries) in Vicksburg, MS.
Eye Care	Increase number of referrals to community resources. Seek out new sources for getting eye exams for veterans who do not qualify at VA.
Glasses	Increase referrals for glasses with local Lion's Club. Seek additional resources in community. If possible, we would like to work with pilot project in FY 2006 by VA related to use of faith-based organizations.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **67 Non-VA staff Participants: 93.3%**
Homeless/Formerly Homeless: **55.2%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.99	.0%	3.47
Food	4.01	3.0%	3.80
Clothing	3.63	5.0%	3.61
Emergency (immediate) shelter	3.88	10.0%	3.33
Halfway house or transitional living facility	4.06	12.0%	3.07
Long-term, permanent housing	2.03	65.0%	2.49
Detoxification from substances	4.07	2.0%	3.41
Treatment for substance abuse	4.32	7.0%	3.55
Services for emotional or psychiatric problems	4.2	5.0%	3.46
Treatment for dual diagnosis	4.1	2.0%	3.30
Family counseling	3.37	3.0%	2.99
Medical services	4.14	7.0%	3.78
Women's health care	3.40	8.0%	3.23
Help with medication	4.00	2.0%	3.46
Drop-in center or day program	3.21	2.0%	2.98
AIDS/HIV testing/counseling	4.03	.0%	3.51
TB testing	4.00	.0%	3.71
TB treatment	3.89	.0%	3.57
Hepatitis C testing	3.92	.0%	3.63
Dental care	3.30	23.0%	2.59
Eye care	2.83	16.0%	2.88
Glasses	2.60	15.0%	2.88
VA disability/pension	3.46	15.0%	3.40
Welfare payments	2.86	3.0%	3.03
SSI/SSD process	2.94	3.0%	3.10
Guardianship (financial)	2.80	2.0%	2.85
Help managing money	3.17	.0%	2.87
Job training	3.00	23.0%	3.02
Help with finding a job or getting employment	3.27	15.0%	3.14
Help getting needed documents or identification	3.47	5.0%	3.28
Help with transportation	3.36	8.0%	3.02
Education	3.10	8.0%	3.00
Child care	2.02	8.0%	2.45
Legal assistance	2.51	13.0%	2.71
Discharge upgrade	2.84	2.0%	3.00
Spiritual	3.73	.0%	3.36
Re-entry services for incarcerated veterans	2.94	7.0%	2.72
Elder Healthcare	3.21	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.75
Co-location of Services - Services from the VA and your agency provided in one location.	1.81
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.04
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.11
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.74
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.70
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.08
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.22
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.07
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.69
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.00

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC New Orleans, LA - 629

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2750

2. Estimated Number of Veterans who are Chronically Homeless: 578

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2750 (estimated number of homeless veterans in service area) **x chronically homeless rate (21 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	0	400
Transitional Housing Beds	175	187
Permanent Housing Beds	0	300

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Medical Services	The greatest need since the storm is medical services. The plan is to keep homeless veterans aware of medical services as they become available.
Long-term, permanent housing	This is the second greatest needs since the storm. The plan is to purchase housing vouchers in Jefferson Parish where there was less storm damage.
Immediate shelter	The third greatest need after Katrina is immediate shelter. The plan is to maintain regular contact with the local shelters for the purpose of accessing services and receiving referrals.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **15 Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **46.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.14	.0%	3.47
Food	3.71	.0%	3.80
Clothing	3.38	.0%	3.61
Emergency (immediate) shelter	2.86	7.0%	3.33
Halfway house or transitional living facility	3.36	20.0%	3.07
Long-term, permanent housing	2.86	33.0%	2.49
Detoxification from substances	3.27	27.0%	3.41
Treatment for substance abuse	3.20	40.0%	3.55
Services for emotional or psychiatric problems	3.0	20.0%	3.46
Treatment for dual diagnosis	3.2	47.0%	3.30
Family counseling	2.50	7.0%	2.99
Medical services	4.00	.0%	3.78
Women's health care	3.27	.0%	3.23
Help with medication	3.67	.0%	3.46
Drop-in center or day program	2.57	13.0%	2.98
AIDS/HIV testing/counseling	3.57	.0%	3.51
TB testing	4.00	.0%	3.71
TB treatment	3.86	.0%	3.57
Hepatitis C testing	3.67	.0%	3.63
Dental care	2.71	7.0%	2.59
Eye care	3.20	.0%	2.88
Glasses	2.93	.0%	2.88
VA disability/pension	3.07	7.0%	3.40
Welfare payments	2.79	.0%	3.03
SSI/SSD process	2.79	13.0%	3.10
Guardianship (financial)	2.67	.0%	2.85
Help managing money	2.60	7.0%	2.87
Job training	2.86	7.0%	3.02
Help with finding a job or getting employment	2.79	13.0%	3.14
Help getting needed documents or identification	2.57	7.0%	3.28
Help with transportation	2.79	7.0%	3.02
Education	3.00	.0%	3.00
Child care	2.07	.0%	2.45
Legal assistance	3.14	.0%	2.71
Discharge upgrade	2.87	.0%	3.00
Spiritual	3.47	7.0%	3.36
Re-entry services for incarcerated veterans	2.47	13.0%	2.72
Elder Healthcare	2.64	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.40
Co-location of Services - Services from the VA and your agency provided in one location.	1.53
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.93
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.60
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.67
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.21
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.13
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.20
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.67
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.60
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.13

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.73
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.47

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Oklahoma City, OK - 635

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 520

2. Estimated Number of Veterans who are Chronically Homeless: 192

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 520 (estimated number of homeless veterans in service area) **x chronically homeless rate (37 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	520	0
Transitional Housing Beds	240	0
Permanent Housing Beds	0	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Attempt to identify builders and people in the construction business who will build or renovate housing for low-income and homeless.
Help finding a job or getting employment	More job fairs. Educate businesses on hiring veterans with felony records. HVRP for job incentives.
Transportation	Homeless alliance implemented bus service for the homeless.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **28 Non-VA staff Participants: 61.5%**
Homeless/Formerly Homeless: **32.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.48	7.0%	3.47
Food	3.70	7.0%	3.80
Clothing	3.37	4.0%	3.61
Emergency (immediate) shelter	3.58	7.0%	3.33
Halfway house or transitional living facility	3.12	4.0%	3.07
Long-term, permanent housing	2.41	48.0%	2.49
Detoxification from substances	3.80	15.0%	3.41
Treatment for substance abuse	3.77	11.0%	3.55
Services for emotional or psychiatric problems	3.4	.0%	3.46
Treatment for dual diagnosis	3.3	11.0%	3.30
Family counseling	3.04	4.0%	2.99
Medical services	3.85	7.0%	3.78
Women's health care	3.07	7.0%	3.23
Help with medication	3.37	7.0%	3.46
Drop-in center or day program	2.92	7.0%	2.98
AIDS/HIV testing/counseling	3.50	.0%	3.51
TB testing	3.68	.0%	3.71
TB treatment	3.44	.0%	3.57
Hepatitis C testing	3.74	.0%	3.63
Dental care	2.48	19.0%	2.59
Eye care	2.60	4.0%	2.88
Glasses	2.60	4.0%	2.88
VA disability/pension	3.46	15.0%	3.40
Welfare payments	2.92	.0%	3.03
SSI/SSD process	3.00	4.0%	3.10
Guardianship (financial)	2.71	.0%	2.85
Help managing money	2.71	4.0%	2.87
Job training	2.96	15.0%	3.02
Help with finding a job or getting employment	3.04	22.0%	3.14
Help getting needed documents or identification	3.38	4.0%	3.28
Help with transportation	2.80	26.0%	3.02
Education	2.85	7.0%	3.00
Child care	2.28	.0%	2.45
Legal assistance	2.20	15.0%	2.71
Discharge upgrade	2.87	.0%	3.00
Spiritual	3.08	.0%	3.36
Re-entry services for incarcerated veterans	2.48	11.0%	2.72
Elder Healthcare	3.16	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.93
Co-location of Services - Services from the VA and your agency provided in one location.	1.43
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.57
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.86
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.13
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.40
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.13
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.36
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.33
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.33
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.47
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.47

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.67
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.31

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Shreveport, LA - 667

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 147

2. Estimated Number of Veterans who are Chronically Homeless: 51

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 147 (estimated number of homeless veterans in service area) **x chronically homeless rate (35 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	200	15
Transitional Housing Beds	88	40
Permanent Housing Beds	20	40

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue working with Shelter Plus Care to place veterans under housing voucher. Continue to encourage veterans to save money for housing when discharged from VA transitional housing program. Continue to look for other housing sources and opportunities.
Dental care	Make referrals to VA Dental Services early in the program because there is a long waiting time for appointments; also see if Dental Services can see critical cases earlier. Contact community dentist to look for sources for emergency dental care.
VA disability/pension	Schedule appointments with VA Service Representatives to find out more information and see if they would consider meeting with our clients as a group. Provide bus passes for veterans to go to the VA representative's office.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **79** **Non-VA staff Participants: 70.3%**
Homeless/Formerly Homeless: **54.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.67	.0%	3.47
Food	3.85	10.0%	3.80
Clothing	3.51	2.0%	3.61
Emergency (immediate) shelter	3.88	9.0%	3.33
Halfway house or transitional living facility	3.89	6.0%	3.07
Long-term, permanent housing	2.97	43.0%	2.49
Detoxification from substances	4.07	6.0%	3.41
Treatment for substance abuse	4.05	7.0%	3.55
Services for emotional or psychiatric problems	3.8	12.0%	3.46
Treatment for dual diagnosis	3.5	8.0%	3.30
Family counseling	2.97	5.0%	2.99
Medical services	4.13	3.0%	3.78
Women's health care	3.07	2.0%	3.23
Help with medication	3.86	9.0%	3.46
Drop-in center or day program	2.88	8.0%	2.98
AIDS/HIV testing/counseling	3.81	5.0%	3.51
TB testing	3.96	.0%	3.71
TB treatment	3.82	.0%	3.57
Hepatitis C testing	4.11	2.0%	3.63
Dental care	2.44	42.0%	2.59
Eye care	3.24	5.0%	2.88
Glasses	3.28	8.0%	2.88
VA disability/pension	3.00	24.0%	3.40
Welfare payments	2.69	5.0%	3.03
SSI/SSD process	2.77	6.0%	3.10
Guardianship (financial)	2.64	2.0%	2.85
Help managing money	3.20	3.0%	2.87
Job training	2.89	14.0%	3.02
Help with finding a job or getting employment	2.91	11.0%	3.14
Help getting needed documents or identification	3.20	6.0%	3.28
Help with transportation	3.20	5.0%	3.02
Education	3.18	9.0%	3.00
Child care	2.46	2.0%	2.45
Legal assistance	2.70	8.0%	2.71
Discharge upgrade	2.65	3.0%	3.00
Spiritual	3.45	11.0%	3.36
Re-entry services for incarcerated veterans	2.83	9.0%	2.72
Elder Healthcare	3.10	2.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.41
Co-location of Services - Services from the VA and your agency provided in one location.	2.09
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.11
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.18
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.86
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.95
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.23
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.12
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.07
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.16

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.88
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.90

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Muskogee, OK-623 (Tulsa, OK)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 250

2. Estimated Number of Veterans who are Chronically Homeless: 35

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 250 (estimated number of homeless veterans in service area) **x chronically homeless rate (14 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	600	25
Transitional Housing Beds	10	80
Permanent Housing Beds	0	15

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Begin admitting veterans to VA Grant and Per Diem Program.
Treatment for substance abuse	Ensure that veterans admitted to VA Grant and Per Diem program receive treatment and follow-up at VA Medical Center or VA outpatient clinic.
Services for emotional or psychiatric problems	Begin utilizing nurse care managers for intensive case management referrals.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **19** **Non-VA staff Participants: 84.2%**
Homeless/Formerly Homeless: **5.3%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.74	.0%	3.47
Food	4.42	6.0%	3.80
Clothing	4.16	.0%	3.61
Emergency (immediate) shelter	3.89	11.0%	3.33
Halfway house or transitional living facility	2.53	22.0%	3.07
Long-term, permanent housing	2.28	56.0%	2.49
Detoxification from substances	2.63	11.0%	3.41
Treatment for substance abuse	2.53	28.0%	3.55
Services for emotional or psychiatric problems	2.7	11.0%	3.46
Treatment for dual diagnosis	2.5	11.0%	3.30
Family counseling	3.00	.0%	2.99
Medical services	3.53	6.0%	3.78
Women's health care	3.32	.0%	3.23
Help with medication	3.37	.0%	3.46
Drop-in center or day program	4.05	.0%	2.98
AIDS/HIV testing/counseling	4.06	.0%	3.51
TB testing	4.32	.0%	3.71
TB treatment	4.11	.0%	3.57
Hepatitis C testing	3.68	.0%	3.63
Dental care	1.79	44.0%	2.59
Eye care	2.47	6.0%	2.88
Glasses	2.74	6.0%	2.88
VA disability/pension	3.47	6.0%	3.40
Welfare payments	3.41	.0%	3.03
SSI/SSD process	2.58	22.0%	3.10
Guardianship (financial)	2.79	6.0%	2.85
Help managing money	2.68	6.0%	2.87
Job training	3.05	6.0%	3.02
Help with finding a job or getting employment	3.11	11.0%	3.14
Help getting needed documents or identification	3.56	6.0%	3.28
Help with transportation	3.37	6.0%	3.02
Education	3.26	.0%	3.00
Child care	2.74	.0%	2.45
Legal assistance	2.79	.0%	2.71
Discharge upgrade	3.05	.0%	3.00
Spiritual	3.32	.0%	3.36
Re-entry services for incarcerated veterans	2.63	11.0%	2.72
Elder Healthcare	2.95	6.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.88
Co-location of Services - Services from the VA and your agency provided in one location.	1.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.40
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.69
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.38
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.63
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.25
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.63
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.80
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.31

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.67
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.88